STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	008900	A. BUILDING: _____ B. WING _____	10/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL- INDIANAPOLIS	8060 KNUE ROAD INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Date of survey: 10/29/14 Facility number: 008900 Complaint number: IN00157206 Unsubstantiated; Lack of sufficient evidence. Surveyor: Marcia Anness. RN Public Health Nurse Surveyor Select Specialty Hospital-Indianapolis is in compliance with 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules. QA: claughlin 01/23/15	S 000		